State of Tennessee

www.state.tn.us.tenncare/Providers/enroll.html

PROVIDER ADDRESS CHANGE AND TERMINATION FORM

1. **Group Provider Name:** _____ **Provider No.:** _____
   (Hospitals, clinics, groups such as LLC's, PLLC's, PC's, nursing homes, suppliers, corporations, and other group providers).
2. **Individual Provider Name:** _____ **Provider No.:** _____
   (Providers in solo practice only).
3. **I.R.S. Number:** _____
4. **New Servicing Address:** _____
   _____
   _____
5. **New Pay To Address:** _____
   _____
   _____

NOTE: PLEASE ATTACH A SUBSTITUTE W-9 FORM IF YOUR PAY-TO ADDRESS CHANGES. PLEASE NOTIFY THE PROVIDER ENROLLMENT OFFICE WHEN AN INDIVIDUAL PROVIDER OR A GROUP TERMINATES.

6. **Group Name:** _____ **Grp. Prov. #** _____ **Term. Date:** / /
7. **Ind. Prov. Name:** _____ **Ind. Prov. #** _____ **Term. Date:** / /
8. **Ind. Prov. Name:** _____ **Ind. Prov. #** _____ **Grp. #** _____ **Term. Date:** / /
9. **Ind. Prov. Name:** _____ **Ind. Prov. #** _____ **Grp. #** _____ **Term. Date:** / /
10. **Ind. Prov. Name:** _____ **Ind. Prov. #** _____ **Grp. #** _____ **Term. Date:** / /

IF THERE IS AN OWNERSHIP, NAME AND/OR IRS NUMBER CHANGE, PLEASE CONTACT THE PROVIDER ENROLLMENT OFFICE FOR A NEW APPLICATION PACKET.

Physician's Signature: _____
or
Authorized Representative: _____

Title: _____

Date: _____

Telephone Number: _____

DO NOT ALTER THIS FORM IN ANY MANNER. SHOULD YOU HAVE QUESTIONS REGARDING THE COMPLETION OF THE FORM, PLEASE CALL 1-800-852-2683.

RETURN TO: PROVIDER SERVICES
State of Tennessee
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243 1700